THE MEDICO-LEGAL ASPECTS OF ANAESTHESIA*

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AT THIS TIME of frequent and sometimes profound adjustments in our professional environment, we must occasionally deviate from purely academic and administrative preoccupations and consider matters relating to our place in society.

Many of us were educated in the earlier years of this century. We were influenced by teachers, many of whom were dedicated clinicians of the old school. They introduced us to a comfortable and uncomplicated form of ethical medical practice. The relationship existing between the physician and his patient was profound. The patient had implicit confidence in a single source of professional care. The physician responded with an exemplary dedication to the needs of his community.

Since that time much has occurred to alter inevitably the relationship between the doctors and the people. Progress has resulted in an increase in the number of medical disciplines. Hospitals have become more departmentalized. Population increases have expanded the clinical loads. Acute clinical problems have become concentrated in specialized units. Postgraduate training programs and clinical teaching units have been organized and have resulted in much delegation of clinical responsibility. The family physician is often not a member of the hospital staff. Fortunately, the spontaneous interests of our younger physicians have retained much of the personal relationship that means so much to the patient.

The exigencies of modern hospital activity have materially affected the anaesthetist. In an atmosphere resulting from twenty or more busy operating theatres, and fifty to sixty operations daily, the administrative problems are considerable. The senior anaesthetist has often become the adjutant, responsible for many of the details and decisions emanating from such activity. The patient's welfare must be protected against the hazards that may result from heavy work loads performed by large professional and technical staffs who are sometimes affected by overwork and fatigue. It is unfortunate but true that many of these people have a restricted tenure in the hospital.

Potential medical legal involvements may be the results of a lack of application of ethical, personal, and professional obligations.[1] There are certain routine responsibilities that require constant concern. They refer to the rights of the individual, various aspects of identification, and records. In addition we should keep ourselves informed concerning basic legal responsibilities.

THE MATTER OF CONSENT

The law conscientiously establishes the right of the individual to make personal decisions concerning any physical act to which his body is subjected. Personal

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rights are absolute, and the sane individual may refuse medical treatment even if such refusal is associated with the hazard of death. There are few exceptions. In most instances the voluntary act of seeking medical aid implies consent, and this is recognized by the law. The doctor's advice concerning treatment may result in a verbal consent, and this too is legal. Neither of these forms of consent, however, is considered adequate protection to the parties involved in the event of a surgical operation. Under these circumstances the law requires that a written consent be obtained.

To quote the late Dean Meredith of McGill University, "An unauthorized operation amounts to an actionable assault." The Ontario statutes concerning consent are clear, uncomplicated, and concise.[2] When properly completed, the consent form authorizes the surgeon to proceed with treatment in the hospital. A well constructed form will allow the patient to insert any specific limitations as to treatment he will receive. For various reasons a voluntary consent may be unobtainable. The laws of the province will allow the surgeon to proceed if he believes that delay caused by obtaining such consent would endanger the life of the patient, particularly where the mental condition of the patient is such that there is inability to consent or refuse. The regulations appended to the by-laws of many teaching hospitals may require more. Ample protection is provided by signed consultations recorded by the surgeon and another member of the surgical staff. If another surgeon is not available, the written support of the anaesthetist, as a consultant and also as a member of the attending staff, is quite acceptable. For obvious reasons some hospitals legally record the resident surgeon as a member of the attending staff.

An unmarried patient under the age of 18 is considered to be a minor in the province of Ontario and subject to parental authority. He is therefore not allowed to give consent for surgery on himself. The regulations concerning minors vary considerably with the locality; for instance, in Quebec an emancipated minor (one who is earning his own living) may provide a legal consent at the age of 17. In certain states of the United States the acceptability of the consent of a minor is related to maturity and ability to exercise discretion, rather than to age.

The anaesthetist is routinely involved in the matter of the patient's consent. His preoperative visit affords an important opportunity for personal communication with the patient. He is identified then by the patient as one who will provide an important type of treatment. He is responsible for the general physical condition of the patient with regard to fitness to undergo anaesthesia. His general and special observations must be recorded. A recent report by the executive secretary of the Canadian Medical Protective Association[3] recorded that an anaesthetist was informed preoperatively by the patient of her allergic response to barbiturates. In spite of this, thiopentone anaesthesia was used, resulting in an acute dermatitis, followed by areas of permanent skin pigmentation. It had to be considered that this action on the part of the physician was not defensible. The preoperative visit affords the patient the opportunity to establish limitations as to treatment. A valid consent requires that the recipient be in a completely rational state. Written consents obtained after the administration of premedicant drugs have on occasion been designated as null and void by the courts.

A British court recently gave judgment for the plaintiff who suffered disability following spinal anaesthesia. At the time of the preoperative visit the previous day the patient had requested the anaesthetist not to give her a spinal anaesthetic. The following morning, just before the patient entered the theatre, and after preparation with premedicant drugs, the surgeon influenced the patient to accept a spinal anaesthetic, which the anaesthetist gave. The court ruled that the consent obtained by the surgeon was under duress, and that the patient was then incapable of providing a proper consent because the influence was exerted at the time when the patient was under the influence of drugs.

In actual practice we find that most patients are not unduly concerned about the technical aspects of inhalational anaesthesia. It is of course our responsibility to seek out and apply information that may in any way affect the anaesthetic procedure.

A few years ago the use of spinal anaesthesia was affected by public information concerning certain hazards.[4] In addition, certain patients undoubtedly suffered some degree of morbidity and discomfort from this technique,[5] and we have all encountered a patient who did not want a repetition. To a lesser extent patients have expressed concern regarding other conduction methods. The technical aspects are not within the terms of reference of this paper. Although spinal anaesthetic techniques have improved in safety, and morbidity has been lessened, the patient who expresses any concern should not receive it. We now have sufficient versatility and professional ability to allay any apprehension that the patient may have concerning such matters, without compromising the patient's welfare. We have the ability to advise, to acquire the patient's confidence, and to practise efficiently, and at the same time to respect the patient's wishes.

Consent for the transfusion of blood may be withheld for religious reasons. Jehovah's Witnesses object to blood transfusion on the premise that the Scripture states that God has forbidden the use of blood as a food. The teachings of this sect, however, allow each individual the right to decide. Members are not subjected to an ecclesiastical dictum. The religious convictions of these people should be respected. No one is legally obligated to submit to medical treatment. One may decide concerning his own health or life, providing that decision does not endanger the welfare of others.[6] A New York court in 1962 rejected the application of a hospital which contended that patients voluntarily admitted to hospital should submit to the jurisdiction of the institution and should not be allowed to risk death by refusing transfusion of blood. The contention was that by so doing the patient would be risking suicide. The courts rejected the application, and the judgment stated that the court and not the hospital had the power to make decisions in such matters. The judgment went on to point out that the court could act as guardian of a minor or a mentally incompetent patient, should the necessity arise. There is no total agreement among lawyers and physicians concerning this matter. We must not be confused by the opinions expressed in courts outside of Canada; however, some of these submissions are interesting.

Emanuel Hayt, counsel for the Hospital Association in New York state, contends that in an emergency the physician in good conscience, who in order to save a life risks violation of this prohibition against the use of blood and

transfuses a patient, is not guilty of a serious assault. He contends that the patient would have to prove some damage from the transfusion in order to hold the doctor liable for other than nominal damages.[6]

Dr. T. L. Fisher, secretary of the Canadian Medical Protective Association, recorded an active rebuttal of this thesis several years ago: "The duty of the medical profession is to recommend and insist on treatment which, in the light of existing knowledge, is the best available. It is not the duty of the profession to write the laws under which treatment should be given."[7]

Because a Jehovah's Witness happens to be booked for operation the following day, we frequently have occasion to discuss this problem with other members of our staff. Junior colleagues frequently express the opinion that an attempt should be made to obtain a qualification of the patient's refusal to accept transfusion. In my experience this is an error, because the patient's decisions are usually absolute, and the attempt to alter them, no matter how discreet, only results in a loss of patient confidence. It is also interesting that there is no reported case in the Canadian or American courts of a physician having been sued by a Jehovah's Witness who received a transfusion of blood, either with or without consent, or contrary to his expressed wishes.[6,8]

The courts have repeatedly ruled that there are limitations to the prerogatives of parenthood. Religious beliefs of parents have not always been allowed to compromise the welfare of a child in need of transfusion. The misfortune is that the acquisition of a court order is a time-consuming legal procedure and in this regard many ethical physicians have attempted to care for paediatric patients under frustrating circumstances. In order to avoid unnecessary delays, recent alterations in the Ontario jurisdiction have established that a court may be convened immediately notice is received of the need for the emergency transfusion of blood.[7] The Ontario Juvenile Courts will provide a decision at any time, day or night. A similar situation exists in the State of Ohio.

Records

One of the chronic irritations constantly occurring at staff meetings is the routine reminder concerning the inadequacy of records. When first confronted by the responsibilities of a large department dealing with approximately 14,000 anaesthetics per year, one of my first observations was the relative frequency of various types of anaesthetic accidents. These were reported by the members of an extremely competent staff. The second fact was that despite the use of a relatively sophisticated anaesthesia record system, which was computer oriented and in three copies, the records obtained were not adequate to provide all the information required in the event of a litigation relating to any of the accidents that occurred. We therefore decided that records must be duplicated in the event of an anaesthetic accident. It was established that all anaesthetic accidents must be reported immediately they occurred; and if it was considered necessary, a separate detailed accident report in essay form had to be completed and submitted with physical findings and supplemental progress notes until the patient was discharged. After discharge, complete records must be kept of all follow-up visits.

The accident reports which have accumulated include those concerning the usual broken teeth and injured dental prostheses of various types. In actual fact these were seldom a serious problem. A careful, concerned follow-up by a conscientious member of the staff usually resulted in the establishment of good rapport with the patient, who would leave the hospital quite satisfied. These patients were informed that every care was taken and most who had dental problems were impressed by the fact that the anaesthetist did a preoperative dental examination and frequently warned of the possibility of injury to devitalized teeth. In the event of an accident, the necessary emergency treatment only was provided by the hospital dentist.

Despite repetitive warnings, corneal abrasions were relatively frequent and in most cases were preventable. Active and comprehensive postoperative treatment was always established immediately with the co-operation of the department of ophthalmology.

There are certain accidents in anaesthesia that are beyond control. We had a small series of patients in whom removal of an epidural catheter resulted in a length of the catheter breaking off under the skin. In two instances its subcutaneous position resulted in easy removal. In four cases the section of catheter was obviously in the epidural space. In none of these patients was removal by laminectomy undertaken. Complete disclosure of facts was made and a follow-up regimen was established. None of these incidents, the first of which occurred over ten years ago, resulted in any subjective awareness of the incident by the patient, and in no instance did any evidence of irritation occur. However, in the event of any possible future complications, we felt that all parties were adequately protected by complete disclosure of the facts, adequate investigation, periodic follow-up and satisfactory records.

Four instances occurred involving the accidental intra-arterial injection of 2.5 per cent thiopentone. This experience was by no means restricted to the junior members of the anaesthetic staff. No patients suffered from more than temporary discomfort. In one instance 2.5 per cent thiopentone was injected into an intravenous drip running into the dorsum of the patient's foot. The foot was covered by a drape and the resultant oedema went unnoticed. A skin slough occurred that required skin grafting. We were extremely fortunate that no legal action was taken.

Our special accident record was responsible for one patient deciding not to pursue threatened litigation. One of the members of the anaesthetic staff performed an intercostal block on a patient suffering from intractable intercostal neuralgia. The resultant pneumothorax necessitated a prolongation of her stay in hospital, and the husband informed the referring doctor that he was going to sue both the hospital and the anaesthetist. The referring doctor mentioned this to us and we provided him with copies of our records requesting that he discuss the situation with the patient's husband. This record showed that the senior member of the anaesthetic staff had written a consultation note that evening. Prompt and successful underwater suction drainage had been established and the pneumothorax resolved in approximately 24 hours. There was no evidence of any residual disability and there were records of two follow-up visits to her

family practitioner. In addition, complete disclosure of all facts leading to this complication had been made to the patient. She had been informed that this was a complication that was unfortunate, but prompt and successful treatment had been established. We learned later that the patient's husband had sought legal advice, but had been advised not to pursue the matter further.

The Anaesthetist and Combined Responsibility

Twenty-five years ago the surgeon was in charge, and his dominant authority was recognized in the hospital environment and in the courts of law. Many groups have now acquired consultant status, and the participation of many disciplines in modern hospital practice is an inherent part of modern medicine, and is recognized by the law. In the event of an operative mishap it is the duty of the court to consider the duties of those involved, to identify their responsibilities, and "to establish in general terms the standard of care by which to measure each defendant's conduct."[9] The surgeon, the anaesthetist, and the hospital may all be named as defendants, and this is nothing more than the true state of affairs in every operating room every day where nurses, anaesthetists, surgeons, and residents integrate their efforts to provide efficient patient care. Their combined efforts identify the patient, consider the operative procedure, and proceed to a successful result. In addition each group accepts responsibility for acts within its professional terms of reference.

We will not digress by entering into a discussion of operating room mishaps. It is better to consider how anaesthetists are actually protected by the law.[10] In general the conduct required of a physician by the law is little more than the ethical or moral concept of duty that can be expected of a reasonable man of ordinary prudence. Chief Justice Tindal in 1838 stated the situation: "The doctor undertakes to bring to the exercise of his profession a reasonable degree of care and skill. When he fails in this respect, he may have shown professional negligence."[11] A specialist by virtue of his training and experience must maintain standards of treatment and skill above those of the general practitioner. To quote Lord Justice Denning, "In a hospital where a person was ill and came in for treatment, no matter what care was used there was always a risk, and it would be wrong and bad law to say that simply because a mishap occurred, the hospital and doctors were liable. The jury must not therefore find him negligent simply because one of the risks in an operation actually took place, or because in a matter of opinion he made an error in judgment. They should find him guilty when he had fallen short of a standard of reasonable medical care."[11]

These principles are generally recognized in the English courts, and the words "a reasonable standard of medical care," appear frequently in the Common Law of Canada. The quotations I have given are those of eminent jurists of the last century. According to legal authorities who have written on the law of negligence, the doctor is protected by several advantages in the event of litigation. For instance, he is not considered liable in the event of unsuccessful treatment. He is required only to be qualified in a manner similar to his colleagues and to exercise reasonable care.

It is interesting to read of the fundamental requirements of a successful malpractice litigation. The plaintiff must substantiate

1. the existence of a definite physician-patient relationship, the result of which is the responsibility of the physician to patient (plaintiff);
2. a definite relationship between an established breach of duty on the part of the physician and the resultant injury;
3. established proof of the damages sustained by the plaintiff.[12]

In most instances the patient must produce a physician to give expert evidence to prove his case. The defence will naturally produce expert testimony to combat any inference of negligence and to establish that the plaintiff was the recipient of competent and reasonable professional care. Physicians are most reluctant to give evidence that might embarrass a colleague. The legal fraternity has on occasion referred to this as "a conspiracy of silence" by the medical profession. Doctors should realize, however, that a reluctance to contribute to the functions of the law may be an actual derogation of the responsibilities of citizenship. There appears to be a considerable variation between the application of the law of torts in the United States and in the British Commonwealth countries with reference to medical malpractice.[13,14] For instance, in United States courts a case is frequently entered under the doctrine of *res ipsa loquitur*. Under these circumstances, expert testimony may not be required because counsel for the plaintiff will attempt to prove that it is hardly credible that the plaintiff's injury could have been caused in any way except by the defendant's negligence. In other words, "the facts speak for themselves."

This doctrine originated from the recognition of the frequent difficulty imposed on the plaintiff to prove the circumstances of injury when he was not in a position to know how the injury occurred. In many instances the real information was possessed only by the defendant. Prime examples are injuries sustained during anaesthesia. As mentioned, if the patient was unconscious during treatment the plea may be facilitated. In the California courts in particular this premise is a frequent basis for successful legal action against anaesthetists. Judgments have been obtained in this manner for injuries of various types sustained during anaesthesia, on conclusion by the court that the injury resulted from the negligence of the anaesthetist. Peripheral nerve injuries, facial burns, fractures of the jaws and teeth, and injuries to the eyes are but a few causes of such litigations. I would like to mention one famous illustrative case.[13] Mrs. Ybarra was operated on for appendicitis. Postoperatively she had a pain in the right arm which subsequently became partially paralysed. The arm had previously been healthy and the plaintiff had no idea of the cause of her injury. She sued her practitioner, who assisted at the operation, the surgeon, the anaesthetist, and the hospital. She produced medical evidence that the injury was of traumatic origin. The trial court dismissed the action, but the Supreme Court of California reversed the decision and held that the plaintiff had proved a case under the doctrine of *res ipsa loquitur*. To quote the judgment, "we merely hold that when a plaintiff receives unusual injuries while unconscious in the course of medical treatment, all those defendants who had any control over his body or the instrumentation which might have caused the injuries, may properly be called upon to meet the inference of

negligence by giving an explanation of their conduct." This judgment has become famous in the American courts, and frequently quoted in the Common Law. A very similar case tried in the Ontario courts some years ago was dismissed and was not appealed.

The acceptance of this doctrine of *res ipsa loquitur* is undoubtedly one of the principal reasons for the tremendous increase in the number of litigations against members of the medical profession in the United States. It is extremely seldom that this doctrine has been recognized and approved in a medical litigation in the province of Ontario, and in Canada our courts generally speaking do not allow cases to be presented in this manner.

During the past few years we have all been impressed by the reported increased incidence of malpractice litigations in the United States. However, it is reassuring to learn from reports of the Canadian Medical Protective Association published in February 1968, that a comparable situation does not exist in Canada. In the 25 years between 1943 and 1967 the incidence of actions was assessed for each five-year period. Allowing for an increased membership, there was no proportional increase in actions against doctors during any of these five-year periods.

It appears that our profession in Canada still enjoys the confidence of our jurists and the good will of the public. This trust must be maintained by attention to our personal and professional responsibilities, and the maintenance of a high standard of professional care adequately supported by descriptive and accurate records.

Summary

If the anaesthetist maintains his ethical and personal responsibilities to his patient and is diligent in the performance of his functions, he is maintaining the obligations established by law. His activities must be supported by a continuing concern for the welfare of the patient. In the event of a complication, honest disclosure is essential, and the records must be adequate. The patient has the right also to make decisions relating to his personal wishes or his religious convictions. The law offers adequate protection to the conscientious, competent physician.

Résumé

Les exigences de la pratique médicale moderne peuvent facilement conduire à un dialogue moins personnel entre le malade et l'anesthésiste. A mesure que les hôpitaux s'agrandissent et deviennent plus compliqués, il est important que les obligations de l'anesthésistes soient remplies. Il lui faut assumer la responsabilité de vérifier que le malade a accordé son consentement à l'opération. De plus, il lui appartient d'étudier tous les aspects de l'état physique de son malade en rapport avec l'anesthésie. Il lui faut écouter les préférences personnelles du malade concernant les aspects techniques de l'anesthésie. De plus, il lui faut tenir compte de ses croyances religieuses.

S'il survient une complication, la loi va assurer une protection au médecin à la condition que ses dossiers permettent d'établir qu'il a prodigué un traitement adéquat. Il est également tenu à faire une déclaration honnête des faits.

Il peut survenir des accidents anesthésiques dans n'importe quel département. Nous avons discuté les éventualités courantes. S'il survient un accident, il nous faut être objectif, honnête avec le malade et présenter des dossiers complets.

Dans la salle d'opération, il faut reconnaitre que les responsabilités des infirmiers, des chirurgiens et des anesthésistes sont conjointes.

Actuellement le médecin compétent jouit de la protection de la loi. Une poursuite pour malpractice n'a pas de chance de réussir ou d'obtenir gain de cause à moins qu'il soit bien établi en cour que les blessures du malade sont attribuables à la négligence ou à l'incompétence du médecin concerné.

Bien que, aux Etats-Unis, le nombre des poursuites pour malpractice médicale s'accroisse continuellement, l'augmentation ne suit pas la même courbe au Canada. De fait, si l'on tient compte de l'augmentation du nombre de médecins au Canada depuis 1945, l'augmentation du nombre des actions médico-légales n'a pas suivi une courbe semblable.

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